Conservative podiatric management in rheumatoid arthritis: a literature review of evidence and gaps

Cristiana Terregna[1], Fabio Riccardi[2], Alice Volpini[2]

1. *Department of Clinical Science and Translational Medicine, University of Tor Vergata, Rome, Italy*
2. *Department of Biomedicine and Prevention, University of Tor Vergata, Rome, Italy*

Correspondence: cristianaterregna@gmail.com

KeyWords:

Podiatry, rheumatoid arthritis, conservative podiatry, foot health education, narrative review

Abstract

Foot problems are highly prevalent in rheumatoid arthritis (RA) and contribute to pain, disability, and reduced quality of life. Conservative podiatric interventions, including foot orthoses (FO) and foot health education (FHE), can improve foot functionality and reduce pain. However, podiatrists remain underrepresented in rheumatology care teams and their role is often absent from clinical guidelines. This review aimed to evaluate the evidence for conservative podiatric interventions in RA and highlight their impact on patient care.

Methods: *A literature search was performed in PubMed Central (PMC), Scopus, Web of Science, CINAHL, MEDLINE, and ScienceDirect. Eligible designs included randomized controlled trials (RCTs), quasi-experimental studies, cohort and case-control studies, cross-sectional studies and surveys. Methodological quality and levels of evidence were assessed using the Canadian Task Force on Preventive Health Care (CTFPHC) criteria.*

Results: *12 studies were included. RCTs demonstrated that foot orthoses reduce pain and positively influence gait biomechanics. Quasi-experimental and cohort studies reported benefits in plantar pressure distribution and mobility. Callus debridement showed short-term pain reduction, while patient education studies identified persistent gaps in knowledge, delivery, and referral pathways. Cross-sectional studies confirmed the high prevalence of foot deformities and disability, with limited or inconsistent podiatry access across services.*

Conclusions: *Conservative podiatric interventions and FHE are effective and essential in RA management, improving function and quality of life. Despite this, podiatry remains inconsistently integrated within rheumatology care. Strengthening referral pathways and conducting further high-quality research are necessary steps to ensure foot health is recognized as a core element of multidisciplinary RA management.*

Introduction

Rheumathoid arthritis (RA) is an autoimmune disease of the joints, which causes damage to cartilage and bones. It develops into an inflammatory, chronic-relapsing condition that affects the joints with painful symptoms, swelling and erosion along with consequent decline of the movement, quality of life and increased cumulative risk of comorbidity [1].

The pathogenesis of RA is complicated and involves both genetic and external factors. Similar to other autoimmune diseases, RA involves a pathway of T-cell activation in both the initial and progression phases of the disease. Most of the genetic risk loci analyzed are not exclusive to RA, but are also associated with other autoimmune diseases, such as, for example, the non-receptor type 22 (PTPN22), associated, in case of polymorphism, with an increased risk of developing type 1 diabetes, but also with other rheumatic diseases, such as systemic lupus erythematosus, or dermatological diseases, such as vitiligo. Genetic variants in the human leukocyte antigen class II (HLA-II) system, located on chromosome 6, are associated with an increased risk of developing autoimmune diseases, including RA [2].

Additionally, the development of RA is strongly associated with environmental factors. Risk factors consistently reported in the literature include smoking and low socioeconomic status. Other environmental risk factors cited in the literature are infectious in nature, such as, for example, Porphyromonas gingivalis [3].

Foot and ankle are involved in approximately 20% of patients with RA at the time of diagnosis and in 90% of patients with a disease duration greater than 20 years. In rheumatoid arthritis, the ankle-foot area is affected in the following order: forefoot (phalanges and metatarsophalangeal joints), midfoot (talocalcaneal joint and calcaneocuboid joint), hindfoot (talocalcaneal or subtalar joint) and, finally, the ankle (tibiotarsal joint). The most common deformities, due to the involvement of these joints, are hallux valgus, subluxation or dislocation of the metatarsal heads, hammer toes, claw toes and flat valgus foot [4]. The foot suffers from joint destruction, increased ligament laxity and muscle-tendon dysfunction, modifying its biomechanics [4, 5]. Consequently, RA negatively affects the quality of life, pain, function and stability of patients with RA, increasing their disability and making it difficult to carry out the usual tasks that require standing, carrying weight or walking long distances [4, 5, 6].

In 2024, a clinical practice guideline (CPG) for the management of foot and ankle in RA was published, including surgical, pharmacological and podiatric strategies. Though this guideline provides multidisciplinary recommendations, the evidence related to conservative podiatric management was presented as part of a broader framework [7].

Given this background, the aim of this narrative review is to complement those guidelines and to

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evaluate the evidence of benefits of conservative podiatric management, especially foot orthoses (FO), routine podiatric care, debridement and foot-health education (FHE) in patients with foot problems related to RA.

Materials and Methods

A literature search was conducted across CINAHL, Web of Science, Scopus, MEDLINE, ScienceDirect and PubMed Central (PMC). Boolean terms (AND, OR) combined keywords: "podiatry care", "podiatry treatment", "foot health education", "orthoses", and "rheumatoid arthritis", with NOT term excluding "surgery", "pharmacology", "pharmaceuticals", and "medication".

This narrative review adhered to the 2020 PRISMA (Preferred Reporting Items for Systematic reviews and Meta-Analyses) guidelines for transparent study selection, with a flowchart illustrating the process [8].

Inclusion Criteria

Studies with the following characteristics were included: diverse study designs (e.g., randomized controlled trials, case series, cohort studies, cross-sectional studies, surveys); involving patients of all ages diagnosed with RA; evaluating conservative podiatric treatments, FHE interventions, and access to podiatry services; published in english; reporting outcomes related to quality of life or increased access to podiatry services, resulting pain reduction and improved foot function.

Exclusion Criteria

Studies with the following features were excluded: studies on other rheumatic conditions, single case reports; unpublished editorials/conference abstracts; studies lacking specific foot data; studies on surgical or pharmacological treatments.

Study selection was performed manually by two reviewers, including a podiatrist and a researcher in public health and followed a three-phase process, as outlined by the 2020 PRISMA guidelines:

- identification, the total number of studies retrieved from the search string across the aforementioned databases was recorded;
- screening, the duplicates were removed, titles were screened for relevance to the research question, and abstracts were read to confirm adherence to predefined inclusion criteria;
- inclusion, the final phase involved full-text review to select articles for inclusion in this narrative review.

This initial search yielded 444 results. Subsequently, advanced search filters were applied, incorporating the previously mentioned criteria, that were English language, accessible full text, and a publication timeframe from 2004 to 2024. This refinement reduced the results to 204 articles.

The screening phase began with the removal of duplicates identified across databases, eliminating 53 articles from the 204, leaving 151. A further screening step involved analyzing the remaining articles by title, leading to the exclusion of 114 articles deemed irrelevant to the research question or not fully accessible.

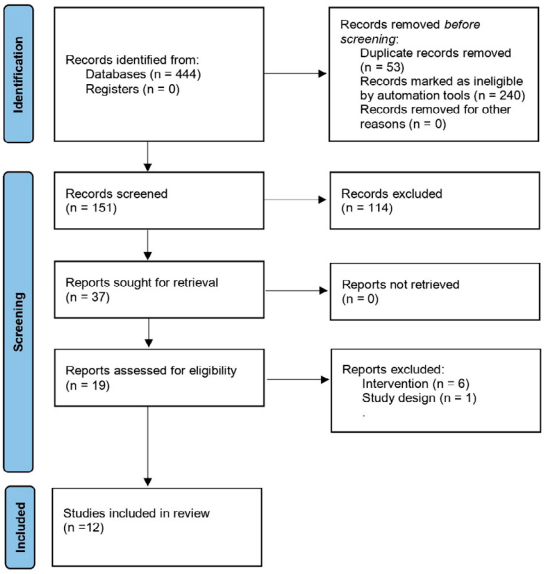

Figure 1. *Flow Chart*

The diagram in Figure 1 shows the scheme that was followed to select the articles.

This process resulted in 37 freely accessible articles, which were then evaluated by abstract analysis, yielding 19 articles. Finally, in the inclusion phase, 12 eligible articles were identified based on study design, intervention type, and reported data.

The levels of evidence of these 12 studies were analyzed according to the guidelines provided by the CTFPHC and published in the Canadian Medical Association Journal (CMAJ). This classification evaluates criteria for identifying the level of evidence and the methodological quality of studies; the latter is assessed by assigning a letter of recommendation based on the methodological quality and consistency of the results [9].

For this narrative review, only the levels of evidence based on study design were evaluated:

- Level I for randomized controlled trials (RCTs);
- Level II-1 RCTs;
- Level II-2 for cohort or case-control studies, preferably conducted at multiple centers;
- Level II-3 for uncontrolled temporal or geographical comparisons, but with relevant results;
- Level III for expert opinions, descriptive studies, or committee reports.

Table 1 presents the levels of evidence and the characteristics of the populations included in the studies analyzed.

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Table 1.

Author, Title, Year	Study Design and CTFPHC Level of Evidence	Participants	Outcome Measures	Results
Siddle H.J. et al., 2013 [15]	RCT – Level I	65 RA patients with painful plantar callosities	VAS; FFI-R; HAQ; FIS; gait parameters	Both groups improved significantly in pain ($p<0.0001$); no long-term functional improvement; debridement useful short-term or in high-risk cases
Gatt A. et al., 2016 [10]	RCT – Level I	9 female patients; mean age 52.2 years; mean RA duration 11.7 years	FFI; Ritchie Articular Index	Both soft and semi-rigid orthoses significantly reduced pain and functional limitation ($p=0.001$)
Bilde Simonsen M. et al., 2022 [11]	Quasi-experimental controlled study – Level II-1	25 RA patients (>18 years)	VAS; gait biomechanics analysis	Significant reduction of pain in foot–ankle complex ($p<0.001$), legs ($p=0.01$), arms ($p=0.012$); no effect on walking speed
van der Leeden M. et al., 2011 [12]	Prospective cohort – Level II-2	135 RA patients (>18 years)	NRS for pain; FFI for function; biomechanical analysis	Pain reduction and functional improvement; better outcomes in patients with shorter disease duration
Carter K. et al., 2017 [21]	QIP time-series– Level II-3	655 patients with inflammatory arthritis including RA	Referral rates to podiatry; patient satisfaction	Podiatry referrals increased by 11%; high patient satisfaction with integrated care
Tenten-Diepenmaat M. et al., 2020 [13]	Quasi-experimental time-series – Level II-3	45 RA patients (38 completed follow-up)	FFI; NRS; in-shoe plantar pressure analysis	Improved foot function and reduced pain ($p<0.05$); non-significant 4% reduction in peak plantar pressure
Hishikawa N. et al., 2022 [14]	Time-series comparative study – Level II-3	31 RA patients with sarcopenia	SAFE-Q; VAS for pain and daily activity	Significant improvements in pain and daily activity ($p=0.01–0.04$); no significant change in social function or general health

Williams A.E., Bowden A.P., 2004 [16]	Cross-sectional study – Level III	139 patients with RA and other rheumatic diseases	FFI; podiatry service access rates	Mean FFI=45; 60% never received podiatry care; podiatry associated with reduced pain and better well-being
Rome K. et al., 2009 [17]	Clinical audit – Level III	100 RA patients; median age 60; median RA duration 15 years	LFIS (LFISIF, LFISAP)	>85% symptomatic callosities; moderate–severe pain/disability; 76% never saw a podiatrist; need for routine podiatry integration
Graham A.S. et al., 2017 [19]	Survey – Level III	543 RA patients with English proficiency and internet access	FHE access, content, delivery, timing	Only 33.7% had received FHE (mostly verbal); 78% preferred education at diagnosis; podiatry education still underprovided
Reina-Bueno M. et al., 2021 [18]	Cross-sectional multicenter – Level III	66 RA patients; mean age 60; mean RA duration 14 years	Morphological/functional assessment; plantar prints; MFPDI; VAS	High prevalence of pronated feet (36–38%), reduced arches (66–68%), hallux valgus (54–59%); VAS mean 6.5; disease duration linked to deformities
Laitinen A-M. et al., 2022 [20]	Cross-sectional survey – Level III	251 RA patients (87% female; mean age 69)	Foot Self-Care Competence questionnaire	Moderate competence (3.5/5); higher in women, those valuing foot health, and those with FHE; podiatry education improves self-care and QoL

VAS = Visual Analogue Scale; FFI-R = Foot Function Index–Revised; HAQ = Health Assessment Questionnaire; FIS = Fatigue Impact Scale; Gait parameters = spatiotemporal and kinematic gait measures; Ritchie Articular Index = joint tenderness score; Gait biomechanics analysis = quantitative assessment of gait; NRS = Numerical Rating Scale; In-shoe plantar pressure analysis = dynamic pressure mapping during gait; SAFE-Q = Self-Administered Foot Evaluation Questionnaire; LFIS (LFISIF, LFISAP) = Leeds Foot Impact Scale (Impairment/Footwear and Activity/Participation subscales); FHE = Foot Health Education; MFPDI = Manchester Foot Pain and Disability Index; Foot Self-Care Competence questionnaire = self-reported foot self-care ability measure.

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Results

A total of 12 studies were included in this review, comprising RCTs, quasi-experimental studies, cohort studies, cross-sectional surveys, and descriptive reports. Study characteristics and key findings are summarized below.

Foot orthoses

Evidence consistently supports the use of custom FO for pain reduction and functional improvement in RA.

Gatt et al. (2016) conducted a pilot RCT crossover in nine female participants, with mean age 52.2 years (standard deviation [SD] 9.1), mean weight 71 kg (SD 12.64), mean height 160 cm (SD 5.18), mean RA duration of 11.7 years (SD 7.83), and a mean ankle/subtalar joint pain duration of 5.7 years (SD 2.62). There were statistically significant reductions in pain, disability, and functional limitation for both soft and semi-rigid orthoses, with improvements particularly evident at the talocrural and subtalar joints ($p = 0.001$) [10].

Bilde Simonsen et al. (2022) reported, in a non-randomized controlled study of 25 patients, significant reductions in foot–ankle pain ($p < 0.001$), as well as perceived pain in the legs ($p = 0.01$) and arms ($p = 0.012$) after four weeks of custom orthoses, compared with control insoles. No significant differences were observed in walking speed ($p = 0.657$) [11].

van der Leeden et al. (2011) followed 135 patients in a prospective cohort study. Custom orthoses significantly reduced foot pain and improved function, particularly in patients with shorter disease duration. Higher baseline disability and longer disease duration were associated with greater clinical benefit: 135 RA patients who were supplied with customised FO. Pain and disability were measured before and after the intervention period using a Numeric Rating Scale (NRS) for foot pain, the Foot Function Index (FFI), the Western Ontario and McMasters Universities Osteoarthritis Index (WOMAC) and a 10-meter walking test. The intervention period consisted of one or more appointments with the podiatrist during which the FO were customised. Swollen foot joint count, foot deformity scores, forefoot peak pressure, disease duration, age, gender, body mass index and baseline values of the outcome measures were selected as potential factors predicting outcome. Multivariate linear regression analyses were performed to determine factors associated with change in pain and disability ($p < 0.05$). Disease duration was negatively associated with the change scores in NRS foot pain ($p = 0.018$), WOMAC pain ($p = 0.001$), FFI disability ($p = 0.003$) and WOMAC physical function ($p = 0.002$) and also age was negatively associated with the change score in 10-meter walking time ($p = 0.008$) [12].

Tenten-Diepenmaat et al. (2020) evaluated 38 patients in a quasi-experimental study in the Netherlands, finding significant improvements in foot pain and function. Among the sample, statistically significant changes in pain (ES 0.69), physical functioning (ES 0.82) and forefoot plantar pressure (ES 0.35) were found. In the subgroup (n = 23) although reductions in peak plantar pressure (~4%) were not statistically significant [13].

Hishikawa et al. (2022) examined 31 patients with RA, of whom 15 with coexisting sarcopenia received FO for six months. foot-specific QoL (measured using the Self-Administered Foot Evaluation Questionnaire [SAFE-Q]), foot pain, activities of daily living, and physical activity were compared before treatment and after 6 months of treatment. Only 10 patients completed the follow-up. Significant QoL improvements were found in the pain and pain-related category and the physical functioning and daily living category ($P = 0.02–0.04$); however, no significant changes were found in the social functioning, general health and well-being, or shoe-related categories ($P = 0.09–0.21$) [14].

Podiatric care and debridement

Siddle et al. (2013) conducted an RCT with 65 RA patients presenting painful plantar calluses. Both treatments included conservative care, with or without regular sharp debridement; at 18 months, there were no significant between-group differences in Visual Analogue Scale (VAS) foot pain (left foot: $F=0.23$, $p=0.635$; right foot: $F=2.14$, $p=0.148$). Within-group analysis showed significant reductions in pain: treatment arm −16.9 mm (95% CI 9.4–24.4, $p<0.0001$); control arm −17.5 mm (95% CI 9.4–25.5, $p<0.0001$). No meaningful changes were observed in Health Assessment Questionnaire (HAQ), FFI-Revised (FFI-R), Fatigue Impact Scale (FIS), or gait parameters over 18 months. Adverse events were limited: two controls required rescue debridement due to pain/extravasation, and three treatment patients had interim visits for pain (one with tissue breakdown). Overall, scalpel debridement offered no additional long-term benefit compared to combined podiatric care alone in RA patients with plantar callosities. No between-group differences were observed in pain, function, disability or gait outcomes, indicating that debridement did not add long-term benefit beyond the conservative care package [15].

Prevalence of foot problems and access to care

Williams and Bowden (2004) reported, in a cross-sectional study on 139 rheumatology patients (majority RA), a very high prevalence of painful hyperkeratosis (58%), nail disorders (86%), bursitis (19%), and rheumatoid nodules (8%). Over half presented moderate-to-severe deformities such as hallux valgus and hammer toes, with only 51% wearing appropriate footwear and 14% had specialist footwear, but half of these were inadequate. FO were prescribed in just 8%, mostly ineffective. The FFI median was 45 (range 32–80), indicating substantial pain and disability. All patients reported foot pain

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and access to care was limited: 60% had never received foot care, and none had specialist podiatry for rheumatic disease [16].

Rome et al. (2009) audited 100 RA patients in New Zealand, with a median age of 60 (IQR: 51–64) years old and median disease duration of 15 (IQR: 7.3–25) years. There were documented widespread deformities, severe pain and disability through Leeds Foot Impact Scale (LFIS), and radiographic erosions (67%). Seventy-six percent had never been assessed by a podiatrist, highlighting major service gaps [17].

Reina-Bueno et al. (2021) examined 66 Spanish RA patients, reporting a high prevalence of pronated (right 36.8% and left 38.6%) and highly pronated (right 15.8% and left 15.8%) feet, as well as an elevated percentage of low arched footprints (right 68.4 and left 66.7%) and hallux valgus (right 59.6% and left 54.4%). Hallux valgus prevalence, toe deformities and FFI factors were significantly associated with the time since RA diagnosed adjusted for the other factors. The adjusted odds ratio of Hallux valgus prevalence was 4.9 (1.2–19.7). Pain (mean VAS 6.5) and disability (FFI, MFPDI) were substantial, with deformities strongly associated with longer disease duration [18].

Foot-health education and self-care competence

Graham et al. (2017) surveyed 543 RA patients (89.7% female, 85.5% aged 40–69 years, 67.3% with disease duration >5 years) online and found that only 33.7% had received FHE, mostly verbally. and 40% had received podiatry treatment. Most participants valued FHE as very important. Verbal information and website signposting were the most common delivery methods, but only 15% had received written information. 66.3% reported never receiving any foot-related information or education. Preferences for timing showed that 78% wanted FHE at diagnosis. Gender differences were significant: women rated content items higher (p=0.022, medium effect) and were more likely to favour earlier and multiple modes of delivery (p=0.019). Age also influenced needs, with younger patients (<59 years) more likely to report uncertainty about what to ask regarding foot health (p=0.004). Barriers included lack of awareness among health professionals, limited discussion of foot health in consultations (62% not asked about foot health), and poor provision of written materials [19].

Laitinen et al. (2022) surveyed 251 RA patients, reporting moderate overall self-care competence (mean 3.50/5, SD 0.66). Among the composite variables, the highest mean score was observed for attitudes towards foot self-care (3.98; SD 0.69), followed by knowledge of foot self-care (3.45; SD 0.67) and experience in performing foot self-care (3.38; SD 0.69). Higher competence was associated with female sex, greater knowledge, and professional education [20].

Carter et al. (2017) A total of 655 patients with inflammatory arthritis (IA), mainly RA, were seen during the 6-month study period. Of these, 248 patients (38%) presented with IA-related foot problems. Prior to the Quality Improvement Project (QIP), only 2.5 patients per clinic session (≈8% of eligible cases) were referred to podiatry. Following implementation of the interventions, the mean referral rate increased to 3.6 patients per session, and at the end of the project the podiatrist assessed 8 patients per weekly clinic session, fully utilizing consultation capacity. Patient-directed interventions (educational leaflets, posters, video, and a newspaper feature) reached 100% of surveyed patients, who considered the information useful; however, 40% reported difficulty retaining the information and 80% found it too detailed, leading to subsequent simplification of materials. Workflow revisions (reallocation of staff and use of referral checklists) and the introduction of patient self-screening tools with automated referral further improved efficiency and access. In the third "Plan-Do-Study-Act" (PDSA) cycle, 8 patients completed a satisfaction survey: all were satisfied with podiatry assessment and treatment, but 7 were very satisfied with the convenience of walk-in access; 6 of 8 expressed neutral or negative views regarding consultation costs. This prompted the redesign of the multidisciplinary clinic into a fully integrated rheumatology–podiatry consultation model with bundled payment, lowering overall costs [21].

Discussion

RA is a chronic autoimmune disease characterized by synovial inflammation and progressive joint destruction, frequently leading to cartilage and bone damage. The disease typically begins with a symmetric polyarthritis of the small peripheral joints of the hands and feet, and the metatarsophalangeal, talonavicular, and ankle joints are among the most commonly affected [1,2]. Because of weight-bearing demands and biomechanical stress, foot involvement is almost universal in established RA, resulting in pain, deformity, gait disturbance, and reduced quality of life. Common deformities include dorsal subluxation of the metatarsophalangeal joints, hallux valgus, hammer toes, rearfoot valgus, and pes planus [4]. These complications heavily impact mobility, independence, and daily activities, making the foot one of the most disabling sites of RA involvement.

Within this clinical context, podiatry assumes a pivotal role. Conservative podiatric management - including routine podiatric treatment, custom orthoses, appropriate footwear, and structured foot-health education - has the potential to relieve pain, prevent or delay deformity progression, and enhance self-management. Nevertheless, access to specialized podiatry remains infrequent across health systems.

The present review synthesized the results of the studies included (published between 2004 and 2024) and found that the strongest data supports the use of custom FO. Randomized and quasi-experimental

studies consistently demonstrated reduction in foot and ankle pain, improvements in function, and, in some cases, benefits extending to pain perception in the lower and upper limbs. Importantly, van der Leeden et al. showed greater improvement in patients with shorter disease duration, underscoring the clinical value of early podiatric intervention [12]. Hishikawa et al. provided novel insights in patients with RA and sarcopenia, where FO significantly improved pain and daily activities but did not modify broader wellbeing domains, suggesting that podiatric care primarily addresses physical symptoms while psychosocial outcomes require complementary approaches [14].

The role of debridement appears more limited. Siddle et al. found no additional long-term benefit of regular sharp debridement over a comprehensive conservative package, despite significant pain reduction in both groups.

These findings suggest that debridement may be useful for short-term relief or high-risk situations but should not be considered a stand-alone strategy [15].

Observational studies highlighted the scale of unmet needs: high prevalence of deformities, painful hyperkeratosis, inappropriate footwear, and very low referral rates to podiatry [16, 17, 18, 21]. At the same time, education remains a critical but neglected element of care. Graham et al. and Laitinen et al. demonstrated that only a minority of patients received structured education, while self-care competence remained moderate and largely dependent on professional input [19, 20]. Carter et al. showed that relatively simple organizational interventions, such as patient information materials and referral guidelines, can increase podiatry referrals and patient satisfaction. Together, these data illustrate not only the clinical effectiveness of conservative podiatric care but also the systemic gaps limiting its implementation [21].

This summary of evidence has some limitations. Several studies were small or observational, follow-up periods were generally short, and outcome measures varied widely, hindering direct comparison. Only one long-term RCT was available, focused on debridement rather than orthoses. The lack of standardized protocols for orthoses prescription, footwear interventions, and FHE further complicates translation into practice. Future research should prioritize multicenter RCTs with longer follow-up, standardized outcome sets, and cost-effectiveness analyses, including comparisons of custom and prefabricated orthoses.

Despite these limitations, the evidence consistently supports conservative podiatric care as an essential component of multidisciplinary RA management. FO reliably reduces pain and improve function, education enhances patient self-management, and organizational measures expand access to podiatric services. Integrating podiatrists into rheumatology teams, providing structured education from diagnosis onward, and ensuring regular foot assessments are likely to reduce disability, improve quality of life, and prevent long-term complications.

The findings of this review are consistent with the recommendations of the 2024 CPG on foot and ankle management in RA, which also highlighted the role of chiropody, FO and self-care as key components of conservative treatment [7]. However, unlike the CPG, which integrates surgical, pharmacological, and rehabilitative strategies within a multidisciplinary framework, the present review provides a more detailed and focused synthesis of evidence specifically related to conservative podiatric interventions. By concentrating on this area, our work underscores both the clinical benefits already demonstrated, particularly for FO, and the considerable gaps in research limiting the strength of current recommendations. This complementary perspective reinforces the guideline's conclusions while at the same time highlighting the urgent need for additional high-quality trials to consolidate and expand the evidence base for conservative podiatry in RA.

At present, only a limited number of RCTs, the gold standard in clinical research, are available on conservative podiatric management in rheumatoid arthritis. Most of the existing evidence is derived from small-scale, observational, or quasi-experimental studies, which restricts the strength and generalization of the conclusions. This review therefore provides a foundational knowledge base to support and stimulate further research in this field.

Future investigations should prioritize well-designed multicenter RCTs with longer follow-up periods, standardized protocols for orthoses prescription, footwear interventions and foot-health education, as well as the use of consistent outcome measures. In addition, cost-effectiveness analyses will be critical to guide the integration of podiatric care into routine rheumatology services and to optimize healthcare resource allocation.

Conclusions

In conclusion, this narrative review emphasizes the importance of conservative podiatric management in RA. The available studies support the role of the conservative podiatric care in reducing pain, improving mobility and enhancing quality of life. Podiatry represents an essential component of RA care and strengthening its role within a multidisciplinary management frame represents a critical step toward improving patient outcomes and reducing the burden of RA-related foot problems.

The scarcity of RCTs remains a key limitation. Future research should prioritize well-designed RCTs with standardized protocols, long-term follow-up, and cost-effectiveness analyses, to strengthen the evidence base and secure podiatry's role in the comprehensive management of RA.

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***Author Contributions*:** Conceptualization, C.T. and F.R.; methodology, C.T and F.R..; formal analysis, F.R. and A.V.; writing—original draft preparation, C.T and F.R.; writing—review and editing, C.T., F.R. and A.V.; supervision, F.R. and A.V. All authors have read and agreed to the published version of the manuscript. Authorship must be limited to those who have contributed substantially to the work reported.

***Institutional Review Board Statement*:** Not applicable.

***Data Availability Statement*:** No new data were created in this study. Data sharing is not applicable.

***Acknowledgments*:** Not applicable.

***Conflicts of Interest*:** The authors declare no conflict of interest.

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